



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING  
Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
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August 25, 2010

Ms. Sonya Saltis, Administrator  
Saltis Home  
1141 Main Street  
Castleton, VT 05735

Dear Ms. Saltis:

Enclosed is a copy of your acceptable plans of correction for the annual survey conducted on **August 10, 2010**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN  
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/10/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALTIS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1141 MAIN STREET CASTLETON, VT 05735</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments:  An unannounced onsite licensing survey was conducted 8/10/2010.	R100	RECEIVED Division of  AUG 24 10  Licensing and Protection	In Progress! will complete asap. no later than 8/31/10.
R148 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.9.c (5)  Assure that residents' medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem;  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN failed to assure that all medications for 1 of 2 applicable residents (Resident #1) had a supporting medical diagnosis or problem. Findings include:  1. Per record review on 8/10/2010, the current MAR (Medication Administration Record) for Resident #1 contained orders for "Risperidone 0.5 mg (milligram) 2 tabs by mouth at bedtime for 3-4 days before Risperdal injection", "Loratadine img: take 1 tablet by mouth every day as needed" and "Opened HCFA cmc (micrograms): inhale 2 puffs in the morning & every 4 hours as needed". Per interview at 10:55 AM, the Manager confirmed that none of these ordered medications indicated a reason or conditions for use.	R148	1) Although I knew what the PRN's were to used for it is correct that it was not clearly written out. I will make sure the doctor writes out clearly why the PRN is to used. I will also review with nurse and other staff and have all of us sign off on it. I have begun working on this.  8-24-10 R148 POC accepted. C. Laramy, RN	
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.g Homes must establish procedures for	R171		

Division of Licensing and Protection

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

JWKF11

If continuation sheet 1 of 5

*Sanya Subito 8/22/10 (manager)*

Division of Licensing and Protection

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NAME OF PROVIDER OR SUPPLIER  SALTIS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 MAIN STREET CASTLETON, VT 05735		
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R171	<p>Continued From page 1</p> <p>documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:</p> <p>(1) Documentation that medications were administered as ordered;</p> <p>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;</p> <p>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;</p> <p>(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and</p> <p>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.</p> <p>(6) All incidents of medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to develop / implement procedures to monitor side effects of psychotropic medications for 2 of 2 applicable residents (Resident #1 and Resident #2) in the sample. Findings include:</p> <p>1, Per record reviews on 8/10/2010, Resident #1 is administered the psychotropic Zyprexa 2.5 mg (milligrams) PO (orally) at noon QD (daily), Zyprexa 5 mg at HS (bedtime), Risperdal Consta 50 mg injectable IM (intramuscularly) every 2 weeks. No documentation was available that indicated routine monitoring for the side effects of these medications, including the potentially irreversible TD (Tardive Dyskinesia) side effect linked to these medications. During interview at</p>	R171	<p>1) I have notified RMH already. They have told me they will mail out all copies of residents' med checks and care plans. The doctor checks for side effects often and they have assured me they will send out paperwork saying so. I will also ask medical doctors to check for TD's during med checks and indicate so on paperwork. I will review this procedure on progress notes.</p> <p>8-24-10 R171 POC accepted C. Lurancy, RN</p>	<p>In progress - will complete asap - no later than 8/31/10.</p>

Sonya Paltas (manager) 8/22/10

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R171	Continued From page 2  12:20 PM, the Manager confirmed that there was no process in place to monitor the side effects of these medications.  2. Per record review on 8/10/2010, Resident #2 is administered the psychotropic medication Thioridazine 25 mg PO daily. No documentation was available that indicated routine monitoring for the side effects of this medication. During interview at 1:10 PM, the Manager confirmed that there was no process in place to monitor the side effect of this medication.	R171	I knew doctors and case managers are always looking for QDS. I know the importance of following this up with written documentation.  8-24-10 R171 POE accepted. C. Luraway, RN	In progress - will complete asap - no later than 8/31/10.
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services  5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:  (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and	R179	Myself and my staff have almost completed out 12 hours (including the seven rules). We will have nurse review and sign off on these training by end of August. I have completed 3 online trainings with VH Care Association. (Staff 2) has completed the same + Adult CPR, A&C, and Emergency Care with A. Red Cross.	Will be completed by 8/31/10 (SS)

Division of Licensing and Protection  
STATE FORM

6899

JWKF11

If continuation sheet 3 of 5

8-24-10 R179 POE accepted.  
C. Luraway, RN

Danya Saltis (manager) 8/22/10-

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R179	Continued From page 3  (7) General supervision and care of residents.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not ensure that 2 of 2 staff reviewed had completed 12 hours of annual training. Findings include:  Per record review on 8/10/2010, 2 staff persons providing direct care had no evidence of attendance for any educational training. During interview at 10:55 AM, the Manager confirmed that no education had been completed for these 2 staff members.	R179		
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.12.b. (3)  For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that resident records contained staff progress notes and an updated plan of care regarding a change in condition for 1 of 2 applicable residents (Resident #1). Findings include:	R189	I agree that a complete progress note had not been completed. I know this Resident had excellent care but I needed to fill out progress notes on this Resident. I will make sure this happens for now on. I will always call the nurse in future. I knew she was on call and I did set up a follow up	8/22/10 completed and understood. (SS)

*Sonya Saltis 8/22/10 (manager)*

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R189	Continued From page 4  1. Per record review on 8/10/2010, a discharge summary following a single day hospitalization (7/3/2010) for a surgical procedure was present in the record for Resident #1. There were no staff progress notes indicating post surgical assessments of the resident's wound and / or physical status had occurred. During interview at 11:45 AM, the Manager confirmed that there were no progress notes in the record of this resident describing the post surgical care, nor had the home's RN been aware that the surgery had occurred to enable the development of a post operative plan of care.	R189 <i>P-24-10 R189 POC accepted. — C. Haraway, RN</i>	Doctor's appt. for this resident 2 days after discharge. I will absolutely make sure nurse is aware next time. I had done so in the past and I should have. <b>SS</b> I will work on completing more consistent progress notes on all residents.	8/22/10 <b>SS</b>
R291 SS=C	IX. PHYSICAL PLANT  9.6 Plumbing  9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas.  This REQUIREMENT is not met as evidenced by: Based on observation, the home failed to assure that water temperatures do not exceed 120 degrees Fahrenheit (DF). Findings include:  1. Per observation during initial tour on 8/10/2010 at 9:00 AM, with the Manager, water temperatures in one 1st floor bathroom and one 2nd floor bathroom were 123.1 and 126.1 respectively. The Manager confirmed that the temperatures exceeded 120 DF and that a regular system of monitoring water temperatures had not been completed.	R291	I will check water temp 1st day of every month as I check my fire extinguisher. The problem has been corrected.  <i>P-24-10 R291 POC accepted. — C. Haraway, RN</i>	8/22/10 <b>SS</b>

*Sonye Salas (manager) 8/22/10 ✓*